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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05119

5132

# CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Charles	MARYLAND	STATE Md.	COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN La Plata, Md.	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN La Plata, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) ETHEL (Middle) Lee (Last) BARNES		4. DATE OF DEATH (Month) May (Day) 30 (Year) 1957	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH May 18 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bank Clerk		10b. KIND OF BUSINESS OR INDUSTRY Banking	9. AGE last birthday 73 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M. Barnes		14. MOTHER'S MAIDEN NAME Ellen Nalley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. unk at present	
17. INFORMANT & ADDRESS Henry R. Barnes, La Plata, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
ANTECEDENT CAUSE(S) DUE TO Arteriosclerotic heart disease		5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Previous coronary		2 mos.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1 APR 1957 to 30 MAY 1957, that I last saw the deceased alive on 30 MAY 1957, and that death occurred at 4:20 P.M. from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS (Street, city, town, state) La Plata DATE SIGNED 30 May 57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 1, 1957	
NAME OF CEMETERY OR CREMATORY Mt. Rest		LOCATION (City, town, or county) La Plata, Maryland	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE JUN 4 1957		Huntt Funeral Home, Waldorf, Md.	

57

May 18 1884

8255

Retired Bank Clerk Banking

William M. Barnes

Ellen Waller

Hand R James to Hato Mo

BUREAU V. S.

JUN 4 1957

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2011.11.27 15:15

Handwritten text (likely bleed-through from the reverse side):  
 1949  
 1949

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

5133

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05120

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Medley</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <i>6 A N St S.W</i> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ANNA MARIE CLARKE</i>		4. DATE OF DEATH <i>5 18 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-24-31</i>
9. AGE (In years last birthday) <i>26 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LAUNDERER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DRY-CLEANING</i>	
11. BIRTHPLACE (State or foreign country) <i>LABATA Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>CHARLES JAMES CLARKE</i>		14. MOTHER'S MAIDEN NAME <i>MARY JACKSON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> 816 X DUE TO (b) <i>MULTIPLE FRACTURES SKULL</i> DUE TO (c) <i>AUTO ACCIDENT</i> INTERVAL BETWEEN ONSET AND DEATH <i>5-18-57</i> <i>5-18-57</i> <i>5-18-57</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2 car auto accident</i>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, location, or part of body injured.) <i>Thrown from auto in 2 car accident hitting head on road.</i>	
20c. TIME OF INJURY Month, Day, Year <i>5-18 1957</i> 10:30 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>HIGHWAY 4301</i>		20f. (City or town) (County) (State) <i>WALDORF CHAS Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>5-23-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln mem</i>		22d. LOCATION (City, town, or county) (State) <i>Waldorf Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arhart Inc Waldorf Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>5/20/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia W. Casey</i>	

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

12-1-70

BUREAU V. 11

1957

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy **may** be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05122

5134

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Lafayette Md.</i>		LENGTH OF STAY (in this place) <i>9 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cobb Island Md.</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phys. Hm. Hsp.</i>				STREET ADDRESS (If rural give location) <i>1</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Sandra Jane Goodboy</i>				<b>4. DATE OF DEATH</b> (Month) <i>5</i> (Day) <i>27</i> (Year) <i>1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2-14-1863</i>	9. AGE last birthday <i>94</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 MRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wif.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penns.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Yes.</i>	
13. FATHER'S NAME <i>Andrew Caler</i>				14. MOTHER'S MAIDEN NAME <i>Martha Anne Roseburgh</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs. Bell Hunter</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		INTERVAL BETWEEN ONSET AND DEATH	
795.0 IMMEDIATE CAUSE (A) <i>General Visceral Failure</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>1950</i> , 19 <i>50</i> , to <i>5-27</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>5-27</i> , 19 <i>57</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>E. J. Edelen</i>		M. D.		ADDRESS (Street, city, town, state) <i>Lafayette Md.</i>		DATE SIGNED <i>5-27-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-31-57</i>		NAME OF CEMETERY OR CREMATORY <i>Mt Lebanon</i>		LOCATION (City, town, or county) (State) <i>Pittsburgh Pa</i>	
24. REC'D BY REGISTRAR <i>5/28/57</i>		REGISTRAR'S SIGNATURE <i>Julia H. Carey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Arhart Inc. Lafayette Md</i>		ADDRESS	



RECEIVED

MAY 31 1957

BUREAU Y. L.

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF WITNESS	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF WITNESS	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF WITNESS	
35. SIGNATURE OF DECEASED		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESS	
39. SIGNATURE OF DECEASED		40. SIGNATURE OF WITNESS	
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51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESS	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESS	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF WITNESS	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS	
63. SIGNATURE OF DECEASED		64. SIGNATURE OF WITNESS	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF WITNESS	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESS	
75. SIGNATURE OF DECEASED		76. SIGNATURE OF WITNESS	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS	
83. SIGNATURE OF DECEASED		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESS	
87. SIGNATURE OF DECEASED		88. SIGNATURE OF WITNESS	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESS	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESS	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF WITNESS	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05123
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 106
1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Warrick</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>					c. LENGTH OF STAY in 1b <u>3 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Dispensary, Indian Head</u>					d. STREET ADDRESS <u>WARRICK GARDENS, SURRIAN</u>					
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Kerrie K Harrington</u>					4. DATE OF DEATH <u>Month Day Year</u> <u>May 28 1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1956</u>		9. AGE (In years last birthday) <u>10</u> yrs. <u>28</u> Months <u>10</u> Days <u>28</u> Hours <u>19</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Infant)</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>					
11. BIRTHPLACE (State or foreign country) <u>RHODE ISLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Brendon D. Harrington</u>					14. MOTHER'S MAIDEN NAME <u>GLORIA BERRY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Daniel Hagen, Indian Head Md</u>					Address <u>104 Oldson Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture Skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child was in front of car unnoticed by driver who ran her over.</u>					
20c. TIME OF INJURY <u>Month, Day, Year</u> <u>11:05 a.m. May 28, 1957</u>					20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>					20f. (City or town) (County) (State) <u>Indian Head Charles Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Frank G. Susan</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Frank A. Susan MD.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>May 31, 1957</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>					22d. LOCATION (City, town, or county) (State) <u>Indian Head Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home Walcott Md</u>					24a. REGISTRAR'S SIGNATURE <u>Edy Trapp</u>					
ADDRESS <u>—</u>					DATE <u>—</u>					

XXXXXXXXXX

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		JUN 6 1968		MEMPHIS, TENN.	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
JAN 19 1933		MOBILE, ALA.		HIGH SCHOOL		ATTORNEY		HEART DISEASE		SUICIDE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		SIGNATURE OF WITNESS		DATE OF WITNESS		SIGNATURE OF JURY		DATE OF JURY	
JAMES EARL RAY		JUN 6 1968		JAMES EARL RAY		JUN 6 1968		JAMES EARL RAY		JUN 6 1968	

RECEIVED  
JUN 3 1968  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5136

CERTIFICATE OF DEATH

05124

Reg. Dist. No.

100

1. PLACE OF DEATH o. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bryantown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Susie</b> Middle <b>Ann</b> Last <b>Jenifer</b>				4. DATE OF DEATH Month <b>5-6-</b> Day <b>57</b> Year <b>19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1885</b>		9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H. Banks</b>				14. MOTHER'S MAIDEN NAME <b>Anne Butler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Julia Jenifer Bryantown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>448x Congestive heart failure</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Hypertensive heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1953</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>E. J. Edelen</b> M.D.							
PHYSICIAN'S NAME (Type) <b>E. J. Edelen, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home Waldorf, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Julia Poy...</b>	

CERTIFICATE OF DEATH

7150

NAME OF DECEASED Charles		MARRIAGE	
DATE OF DEATH 1957		PLACE OF DEATH BALTIMORE	
AGE 45		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Salesman		CAUSE OF DEATH Heart Disease	

DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH
1912	Baltimore	1957	Baltimore
AGE	SEX	RACE	EDUCATION
45	Male	White	High School
OCCUPATION	CAUSE OF DEATH	MANNER OF DEATH	
Salesman	Heart Disease	Natural	

NAME OF DECEASED George E. Smith		MARRIAGE	
DATE OF DEATH 1957		PLACE OF DEATH BALTIMORE	
AGE 45		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Salesman		CAUSE OF DEATH Heart Disease	

DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH
1912	Baltimore	1957	Baltimore
AGE	SEX	RACE	EDUCATION
45	Male	White	High School
OCCUPATION	CAUSE OF DEATH	MANNER OF DEATH	
Salesman	Heart Disease	Natural	

NAME OF DECEASED George E. Smith		MARRIAGE	
DATE OF DEATH 1957		PLACE OF DEATH BALTIMORE	
AGE 45		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Salesman		CAUSE OF DEATH Heart Disease	

DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH
1912	Baltimore	1957	Baltimore
AGE	SEX	RACE	EDUCATION
45	Male	White	High School
OCCUPATION	CAUSE OF DEATH	MANNER OF DEATH	
Salesman	Heart Disease	Natural	

RECEIVED  
MAY 10 1957  
BUREAU V. S.

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy **1** shall be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

05125

Reg. Dist. No. 180

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (in this place) <u>2 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HUGHESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS' MEMORIAL HOSPITAL</u>		STREET ADDRESS <u>1</u>		(If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Ruth</u> <u>Gibbons</u> <u>JONES</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>5</u> - <u>8</u> 19 <u>57</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W-US</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>2-20-1887</u>	<b>9. AGE last birthday</b> <u>70</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13. FATHER'S NAME</b> <u>Henry Gibbons</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida V. Joy</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>A.G. Jones Hughesville, md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>260X IMMEDIATE CAUSE (A)</b> <u>DIABETES MELLITUS-HYPERGLYCEMIA</u>						<u>15 YRS</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>CEREBRAL ARTERIO-SCLEROSIS</u>						<u>3 YRS</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>GENERALIZED ARTERIO-SCLEROSIS</u>						<u>10 YRS</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>450.0</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>SEPTEMBER, 1947</u> , to <u>MAY 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 8</u> , 19 <u>57</u> , and that death occurred at <u>1205</u> AM, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>John H. Griffin</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Box #65, Hughesville md.</u>		<b>DATE SIGNED</b> <u>5/8/57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>5-10-57</u>		<b>NAME OF CEMETERY, OR CREMATORY</b> <u>OLD FIELDS Cem</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Hughesville, md.</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>5/13/57</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. S. Mills Pacy</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hunt Funeral Home</u>		<b>ADDRESS</b> <u>Walton, md.</u>	

07 1741-03-1

John

1500A

Henry C. Brown

1912

BUREAU V. 13

1957 13

RECEIVED

0-10 25 100 500 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05126

5138

CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN (RURAL)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANTOWN (RURAL)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>KATHERINE</u> Last <u>McNAMARA</u>				4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 2, 1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Boston, MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick H. RAFTERY</u>				14. MOTHER'S MAIDEN NAME <u>Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>CHARLES R. McNAMARA Bryantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RENAL FAILURE</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>MITRAL VALVULOTOMY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>UNKNOWN</u> <u>NOVEMBER 1952</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>416X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>50</u> , to <u>MAY 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 1</u> , 19 <u>57</u> , and that death occurred at <u>9:10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John H. Griffin</u> M.D. <u>Hughesville, Md.</u> <u>5/3/57</u> PHYSICIAN'S NAME (Type) <u>JOHN H. GRIFFIN</u> <u>HUGHESVILLE, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Calverton</u>		22d. LOCATION (City, town, or county) (State) <u>Boston Mass</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HUNT FUNERAL HOME WALDORE, MD</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>Mrs. F. Shells Posey</u>	

MAY 8 1957



RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5139 CERTIFICATE OF DEATH

05127

Reg. Dist. No. 102

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Transides</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Transides X0</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Wallace</u> Middle <u>Mihhar</u> Last				4. DATE OF DEATH <u>May</u> Month <u>12</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Mihhar</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Carpenter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Edgar Mihhar, Pisgah, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>782.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>782.4</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-7</u> , 19 <u>57</u> , to <u>5-12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-14</u> , 19 <u>57</u> , and that death occurred at <u>9-54</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>La Plata Md.</u> DATE SIGNED <u>5-12-57</u>			
PHYSICIAN'S NAME (Type) <u>J. H. Johnson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Burham</u>		22d. LOCATION (City, town, or county) (State) <u>Transides Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 5/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>S. A. Thompson</u>	

# CERTIFICATE OF DEATH

<p>NAME OF DECEASED  <i>John Doe</i></p>		<p>DATE OF BIRTH  <i>Jan 15 1900</i></p>		<p>PLACE OF BIRTH  <i>St. Louis, Mo.</i></p>	
<p>DATE OF DEATH  <i>Jan 16 1957</i></p>		<p>PLACE OF DEATH  <i>St. Louis, Mo.</i></p>		<p>CAUSE OF DEATH  <i>Heart Disease</i></p>	
<p>SEX  <i>Male</i></p>		<p>RACE  <i>White</i></p>		<p>EDUCATION  <i>High School</i></p>	
<p>OCCUPATION  <i>Teacher</i></p>		<p>RELIGION  <i>Catholic</i></p>		<p>PREVIOUS ILLNESS  <i>None</i></p>	
<p>DATE OF INTERMENT  <i>Jan 17 1957</i></p>		<p>PLACE OF INTERMENT  <i>St. Louis, Mo.</i></p>		<p>NAME OF FUNERAL HOME  <i>St. Louis Funeral Home</i></p>	
<p>NAME OF MINISTER  <i>Rev. John Smith</i></p>		<p>NAME OF CLERGYMAN  <i>Rev. John Smith</i></p>		<p>NAME OF CHURCH  <i>St. Mary's Church</i></p>	
<p>NAME OF BURIAL PLACE  <i>St. Mary's Cemetery</i></p>		<p>NAME OF CEMETERY  <i>St. Mary's Cemetery</i></p>		<p>NAME OF FUNERAL HOME  <i>St. Louis Funeral Home</i></p>	

BUREAU V. 3

May 16 1957

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy **shall** be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05128

5140 **CERTIFICATE OF DEATH**Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		STATE <u>Maryland</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>La Plata, Md.</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Nanjemoy, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>James</u> (First) <u>Emory</u> (Middle) <u>Mills</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>May</u> (Day) <u>21</u> (Year) <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 21 / 57</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>La Plata, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert J. Mills</u>				14. MOTHER'S MAIDEN NAME <u>Thelma James</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>mother</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
760.5 IMMEDIATE CAUSE (A) <u>cerebral contusion during birth</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Prematurity</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>5-20, 1957</u>, to <u>5-22, 1957</u>, that I last saw the deceased alive on <u>5-20, 1957</u>, and that death occurred at <u>3:30 PM</u>, from the causes and on the date stated above.</b> SIGNATURE <u>[Signature]</u> M.D. ADDRESS (Street, city, town, state) <u>La Plata Md</u> DATE SIGNED <u>5-21-57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-23-57</u>		NAME OF CEMETERY OR CREMATORY <u>Baptist</u>		LOCATION (City, town, or county) (State) <u>Nanjemoy, Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Arehart Funeral Home, La Plata, Md.</u>	

2066262 XV 0

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

1957

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX OF BIRTH

12. AGE OF BIRTH

13. OCCUPATION OF BIRTH

14. CAUSE OF BIRTH

15. DATE OF BIRTH

16. TIME OF BIRTH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. SEX OF BIRTH

20. AGE OF BIRTH

21. OCCUPATION OF BIRTH

22. CAUSE OF BIRTH

23. DATE OF BIRTH

24. TIME OF BIRTH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX OF BIRTH

28. AGE OF BIRTH

29. OCCUPATION OF BIRTH

30. CAUSE OF BIRTH

31. DATE OF BIRTH

32. TIME OF BIRTH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX OF BIRTH

36. AGE OF BIRTH

37. OCCUPATION OF BIRTH

38. CAUSE OF BIRTH

39. DATE OF BIRTH

40. TIME OF BIRTH

41. PLACE OF BIRTH

42. DATE OF BIRTH

43. SEX OF BIRTH

44. AGE OF BIRTH

45. OCCUPATION OF BIRTH

46. CAUSE OF BIRTH

47. DATE OF BIRTH

48. TIME OF BIRTH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. SEX OF BIRTH

52. AGE OF BIRTH

53. OCCUPATION OF BIRTH

54. CAUSE OF BIRTH

55. DATE OF BIRTH

56. TIME OF BIRTH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX OF BIRTH

60. AGE OF BIRTH

61. OCCUPATION OF BIRTH

62. CAUSE OF BIRTH

63. DATE OF BIRTH

64. TIME OF BIRTH

65. PLACE OF BIRTH

66. DATE OF BIRTH

67. SEX OF BIRTH

68. AGE OF BIRTH

69. OCCUPATION OF BIRTH

70. CAUSE OF BIRTH

71. DATE OF BIRTH

72. TIME OF BIRTH

73. PLACE OF BIRTH

74. DATE OF BIRTH

75. SEX OF BIRTH

76. AGE OF BIRTH

77. OCCUPATION OF BIRTH

78. CAUSE OF BIRTH

79. DATE OF BIRTH

80. TIME OF BIRTH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX OF BIRTH

84. AGE OF BIRTH

85. OCCUPATION OF BIRTH

86. CAUSE OF BIRTH

87. DATE OF BIRTH

88. TIME OF BIRTH

89. PLACE OF BIRTH

90. DATE OF BIRTH

91. SEX OF BIRTH

92. AGE OF BIRTH

93. OCCUPATION OF BIRTH

94. CAUSE OF BIRTH

95. DATE OF BIRTH

96. TIME OF BIRTH

97. PLACE OF BIRTH

98. DATE OF BIRTH

99. SEX OF BIRTH

100. AGE OF BIRTH

101. OCCUPATION OF BIRTH

102. CAUSE OF BIRTH

103. DATE OF BIRTH

104. TIME OF BIRTH

105. PLACE OF BIRTH

106. DATE OF BIRTH

107. SEX OF BIRTH

108. AGE OF BIRTH

109. OCCUPATION OF BIRTH

110. CAUSE OF BIRTH

111. DATE OF BIRTH

112. TIME OF BIRTH

113. PLACE OF BIRTH

114. DATE OF BIRTH

BUREAU V. 11

APR 24 1957

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05129

5141

## CERTIFICATE OF DEATH

Reg. Dist. No. 160

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BRYANTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS' MEMORIAL HOSPITAL</u>		1		STREET ADDRESS (If rural give location) <u>RURAL - STATE ROUTE #5</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>TIFFANY</u> (Last) <u>RUSSELL</u>				(Month) <u>MAY</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W-LS</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>5-12-1885</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephis Russell</u>				14. MOTHER'S MAIDEN NAME <u>ALICE Cecil</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>ME</u>		17. INFORMANT & ADDRESS <u>Jenkins T. Russell</u> <u>Indian Head, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>RUPTURED OESOPHAGEAL VARIX (HEMORRHAGE)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>RUPTURED OESOPHAGEAL VARIX - HEALED</u>						<u>3/26/57</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE (CHRONIC CARDIAC FAILURE)</u>						<u>15 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>462.1 ABOVE</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5/14/57</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCTOBER, 1947</u> , to <u>5/9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/9</u> , 19 <u>57</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John H. Shuffin</u>		M.D. <u>Hughesville, Md.</u>		ADDRESS (Street, city, town, state) <u>WALTON, Md.</u>		DATE SIGNED <u>5/9/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEROF <u>5-13-57</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY FACE CEM.</u>		LOCATION (City, town, or county) (State) <u>Great Mills, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>5/14/57</u>		REGISTRAR'S SIGNATURE <u>Mrs. F. Mills Bray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>		ADDRESS <u>WALTON, Md.</u>	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7, Film G216, 6/6/57 bh

5:42

## CERTIFICATE OF DEATH

05130

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL or give nearest town) <i>Spring Hill</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Spring Hill</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>WILLIAM EUGENE SANDERS</i>				<i>5 29 1957</i>			
<b>5. SEX</b> <i>M</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Single</i>	<b>8. DATE OF BIRTH</b> <i>may 25, 1883</i>	<b>9. AGE last birthday</b> <i>74</i> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Ret Farmer</i>		<i>Ret Farmer</i>		<i>Charles comd.</i>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>William M Sanders</i>				<i>Mrs Louise Dement</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<i>Dr Sanders Brothers</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5-29-57</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Heart Disease</i>				<i>1954</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>1954</i> <b>to</b> <i>5-29</i> , <b>19</b> <i>57</i> , <b>that I last saw the deceased alive on</b> <i>5-29</i> , <b>19</b> <i>57</i> , <b>and that death occurred at</b> <i>4:30</i> <b>P.M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>L. J. Dedlen</i>		<b>M.D.</b>		<b>ADDRESS</b> (Street, city, town, state) <i>Lafayette Ave</i>		<b>DATE SIGNED</b> <i>5-29-57</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Buried</i>		<b>DATE THEREOF</b> <i>6-2-57</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>St Joseph Church</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Pomfret md.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Julia W Carey</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Arthurt Mc Laphata md.</i>		<b>ADDRESS</b>	
<b>DATE</b> <i>5/31/57</i>							

1. The first step in the process of identifying a problem is to define the problem. This involves identifying the symptoms of the problem and determining the scope of the problem. Once the problem has been defined, the next step is to identify the causes of the problem. This involves identifying the factors that are contributing to the problem and determining the underlying causes. Once the causes have been identified, the next step is to develop a plan to address the problem. This involves identifying the actions that need to be taken to address the problem and determining the resources that will be needed to implement the plan. Finally, the last step in the process is to implement the plan and monitor the results. This involves putting the plan into action and tracking the progress of the plan to ensure that the problem is being addressed effectively.

JUN 3 1957

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5143

# CERTIFICATE OF DEATH

05131

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Charles</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Charles</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LA PLATA</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LA PLATA</u>	STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physician's Memorial</u>		1 ADDRESS	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<u>Marion</u> (First) <u>SMOOT</u> (Last)		<u>5-17-57</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Aug 9 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE last birthday <u>72</u> yrs.
11. FATHER'S NAME <u>Joseph Smoot</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Collins</u>	
15. SOCIAL SECURITY NO. <u>None</u>		16. INFORMANT & ADDRESS <u>Lizzie Smoot LA PLATA MD</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
450.0 IMMEDIATE CAUSE (A) <u>Acute Intestinal Obstruction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Mesenteric Thrombosis</u>		" "	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>		2 YRS	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>570.2</u>			
19a. DATE OF OPERATION <u>5-14-57</u>		19b. MAJOR FINDINGS OF OPERATION <u>Obstruction &amp; Necrosis of Ileum due to Mes Thrombosis</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from May 11, 1957, to May 12, 1957, that I last saw the deceased alive on May 17, 1957, and that death occurred at 9:35 P.M. from the causes and on the date stated above.</b>			
SIGNATURE <u>Larran Jarboe</u> M.D.		DATE SIGNED <u>5-18-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 21 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Newtown M.E.</u>		LOCATION (City, town, or county) (State) <u>LA PLATA MD</u>	
24. REC'D BY REGISTRAR <u>Julia Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HUNTT FUNERAL HOME</u>	
DATE <u>5/24/57</u>		ADDRESS <u>Waldorf MD</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED  
CHARLES  
LA PLATA

NAME OF DECEASED  
CHARLES  
LA PLATA

Physician's Name  
Morton

Mr. C. Morton  
Farmer  
2000 2nd Street  
Ridge Spring  
Maryland  
Age 75  
Cause of Death  
O.A.

BUREAU V. E.

1957

RECEIVED

Physician's Name  
Morton  
2000 2nd Street  
Ridge Spring  
Maryland

INSTRUCTIONS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5144

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G215 5-11-57 et

Reg. Dist. No.

05132600

1. PLACE OF DEATH a. COUNTY Hughesville, Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Ben First Middle Last Wade		4. DATE OF DEATH Month 5 Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1856
9. AGE (In years last birthday) 100 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Retired Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Ralph Wade		14. MOTHER'S MAIDEN NAME Charlotte Greenfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None	
17. INFORMANT Address William B. Wade, Hughesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1957	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. J. Edelen		DATE SIGNED 5-6-'57	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-57	
22c. NAME OF CEMETERY OR CREMATORY St Mary's Cem.		22d. LOCATION (City, town, or county) (State) Bryantown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		24. REGISTRAR'S SIGNATURE Julius Casey	
ADDRESS Waldorf, Md.		24b. REGISTRAR'S SIGNATURE DATE	

MAY 10 1957

RECEIVED